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## Behind Prison Walls: The Failing Treatment Choice for Mentally Ill Minority Youth

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## NOTE

### BEHIND PRISON WALLS: THE FAILING TREATMENT CHOICE FOR MENTALLY ILL MINORITY YOUTH

#### I. INTRODUCTION

On the night of November 12, 2007, Khiel Coppin, eighteen, was killed in a hail of fifteen bullets fired by New York City Police Department (“NYPD”) officers in front of his family’s home in Brooklyn, New York.<sup>1</sup> Many people in the neighborhood blamed this death on the NYPD officers’ use of excessive force.<sup>2</sup> However, the tragedy can be attributed to circumstances that can be traced back as far as five years before Khiel’s death.

Khiel had a history of severe mental illness.<sup>3</sup> He grew up in the poor neighborhood of Bedford-Stuyvesant where violence controlled everything from the sandbox to the street corners.<sup>4</sup> The public school system failed to detect his mental illness.<sup>5</sup> When Khiel was sixteen, he was convicted of three armed robberies and sent to a juvenile detention center in upstate New York.<sup>6</sup> While upstate, Khiel was accused of three assaults against fellow inmates<sup>7</sup> and repeatedly told the juvenile detention staff “[j]ust kill me.”<sup>8</sup> However, Khiel was not diagnosed with

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1. Andy Newman, *As a Life Is Celebrated, A Death Is Questioned*, N.Y. TIMES, Nov. 21, 2007, at B4 [hereinafter Newman, *As a Life Is Celebrated*].

2. See *id.*; John Marzulli, *Khiel Fatal Shooting Case Reignites Issue of Cops vs. Mentally Ill*, N.Y. DAILY NEWS (Nov. 26, 2007), <http://www.nydailynews.com/new-york/queens/khiel-fatal-shooting-case-reignites-issue-cops-mentally-ill-article-1.258442>.

3. See Larry Celona et al., *‘Hairbrush’ Kid Killed by Cops*, N.Y. POST, Nov. 13, 2007, at 5; Andy Newman, *Before Shooting in Brooklyn, a History of Mental Illness and Family Discord*, N.Y. TIMES, Nov. 14, 2007, at B6 [hereinafter Newman, *Before Shooting in Brooklyn*]; Rich Schapiro et al., *Short Life Long on Criminal, Mental Problems*, N.Y. DAILY NEWS, Nov. 14, 2007, at 7.

4. See Lynette Holloway, *Officials Say Health Center Is on Verge of Insolvency*, N.Y. TIMES, Mar. 6, 1994, at 10; Schapiro et al., *supra* note 3, at B4.

5. See Schapiro et al., *supra* note 3, at 7.

6. Newman, *Before Shooting in Brooklyn*, *supra* note 3, at B6.

7. *Id.*; Schapiro et al., *supra* note 3, at 7.

8. Schapiro et al., *supra* note 3, at 7 (internal quotation marks omitted).

a mental illness until the end of his detention.<sup>9</sup> After eighteen months in the detention center, he was sent to Kings County Hospital's psychiatric ward for treatment.<sup>10</sup> When released, Khiel was prescribed antipsychotic and antidepressant medications.<sup>11</sup> However, because there was no one to ensure he took his medicine, he often refused.<sup>12</sup>

On the day of Khiel's death, his mother, Denise Owens, called the Interfaith Medical Center begging for mental health assistance for her son.<sup>13</sup> However, the Interfaith Medical psychologist was unable to meet with Khiel.<sup>14</sup> When Khiel came home that night, he claimed that he had a gun.<sup>15</sup> In her last attempt to save her son, Mrs. Owens called 911.<sup>16</sup> In Mrs. Owens's frantic call to 911, one can hear Khiel screaming, "I've got a gun and I'm gonna shoot you."<sup>17</sup> Several minutes after the first call was placed, the police arrived at Mrs. Owens's apartment.<sup>18</sup> In a manic state, Khiel climbed out of a first floor window in the apartment screaming that he had a gun.<sup>19</sup> As he walked towards the police, he removed a dark object from under his sweatshirt.<sup>20</sup> The police responded by firing twenty rounds, killing Khiel.<sup>21</sup> In the end, the police discovered the dark object Khiel had pulled out was a hairbrush, not a gun.<sup>22</sup>

Mrs. Owens called the police that night as her last resort to obtain appropriate mental health treatment for her mentally ill son.<sup>23</sup> Like many other minority children with mental health disorders, Khiel was ignored in the school system, mishandled by the juvenile justice system, and rejected by community mental health facilities.<sup>24</sup> In short, our systems failed Khiel. This Note addresses the need to improve our systems and prevent losing children like Khiel.

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9. *Id.*

10. *Id.*

11. See Newman, *Before Shooting in Brooklyn*, *supra* note 3, at B6; Schapiro et al., *supra* note 3, at 7.

12. See Newman, *As a Life Is Celebrated*, *supra* note 1, at B4; Schapiro et al., *supra* note 3, at 7.

13. Newman, *Before Shooting in Brooklyn*, *supra* note 3, at B6; Sewell Chan, *Anger Simmers in Bed-Stuy Over Police Shooting*, N.Y. TIMES CITY ROOM (Nov. 16, 2007, 2:36 PM), <http://cityroom.blogs.nytimes.com/2007/11/16/anger-simmers-in-bed-stuy-over-police-shooting/>.

14. Chan, *supra* note 13.

15. *Id.*

16. Newman, *Before Shooting in Brooklyn*, *supra* note 3, at B6; Chan, *supra* note 13.

17. Newman, *Before Shooting in Brooklyn*, *supra* note 3, at B6 (internal quotation marks omitted); see also Chan, *supra* note 13 (providing a recording of Denise Owens's first 911 call).

18. Newman, *Before Shooting in Brooklyn*, *supra* note 3, at B6.

19. Celona et al., *supra* note 3, at 5.

20. *Id.*; Newman, *As a Life Is Celebrated*, *supra* note 1, at B4.

21. Chan, *supra* note 13.

22. Celona et al., *supra* note 3, at 5; Newman, *As a Life Is Celebrated*, *supra* note 1, at B4.

23. See Newman, *Before Shooting in Brooklyn*, *supra* note 3, at B6.

24. See *supra* text accompanying notes 5-14; *infra* Part II.A-C.

The juvenile justice system has become a “surrogate” mental health hospital for minority youth who are unable to access care through the formal mental health system.<sup>25</sup> Rather than addressing mental health issues early on in the school system, society acknowledges them when it is often too late, i.e., in the juvenile justice system.<sup>26</sup> Even then, society does a poor job. Although the laws are designed to protect youth from the harsh reality of the juvenile justice system, the current legislation is ineffective.<sup>27</sup> In order to address this issue, Congress must reform federal laws on mental health treatment both in the school system and at different stages of the juvenile justice system.

This Note proceeds as follows. Part II of this Note discusses the over-representation of minority children with mental health disorders in the juvenile justice system. This Part examines the various causes of over-representation, including zero-tolerance policies in the school system, lack of access to community mental health facilities, and inappropriate discharge plans. In addition, this Part explores the collateral consequences of warehousing youth with mental health disorders in juvenile detention centers.

Part III explores three areas of the system that often fail mentally ill youth. First, this Part reevaluates the Individuals with Disabilities Education Act, particularly its implementation and enforcement. Second, this Part analyzes the effectiveness of the Juvenile Justice Delinquency Prevention Act. Lastly, this Part examines the gap between the statutory rights of juveniles under Medicaid and their actual access to services within the mental health services system. Part IV then offers solutions for the school and juvenile justice systems to address the mental health issues of minority youth.

## II. BACKGROUND

“Our society has long been in denial about mental health issues—especially among its youth.”<sup>28</sup> Approximately 20% of children suffer from some form of mental illness during their childhood.<sup>29</sup> Among incarcerated youth, the prevalence rate of mental illness is significantly

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25. See COAL. FOR JUVENILE JUSTICE, HANDLE WITH CARE: SERVING THE MENTAL HEALTH NEEDS OF YOUNG OFFENDERS, THE SIXTEENTH ANN. REP. TO THE PRESIDENT, THE CONGRESS, & THE ADMINISTRATOR OF THE OFFICE OF JUV. JUST. & DELINQUENCY PREVENTION 14-15, 26 (2000).

26. *Id.* at 14, 27-28.

27. See *infra* Part III.A-B.

28. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 7.

29. *Id.* at 8.

higher.<sup>30</sup> It is estimated that 50% to 75% of youth offenders nationwide have a mental health disorder.<sup>31</sup>

All mentally ill youth are defenseless victims of their disorder.<sup>32</sup> However, “[f]or youth of color, the situation is particularly chronic and severe.”<sup>33</sup> It has long been the case that Black and Latino Americans represent an alarming number of youth entering juvenile detention centers in the United States.<sup>34</sup> African Americans are over-represented at every stage of the juvenile justice system—arrests, pre-adjudication, the judicial waiver process, and the adjudication phase.<sup>35</sup> While African American youth represent 16% of the nation’s youth, they represent 37% of youth in secure placement, and 58% of youth committed to state adult prisons.<sup>36</sup> Equally troubling, minorities are disproportionately represented among youth with mental health issues.<sup>37</sup> It is well known that minorities are over-exposed to aggravating factors that contribute to illegal behavior such as poverty, neighborhood crime, lack of family structure, and racism.<sup>38</sup> But this does not explain why African American juveniles are more likely than white juveniles to be incarcerated in detention centers rather than mental health facilities.<sup>39</sup> One significant reason for this disproportionate minority contact (“DMC”) is that communities of color lack sufficient resources to address the mental health problems of their children.<sup>40</sup> Consequently, rather than receive proper treatment, many mentally ill children are sent to ill-equipped juvenile detention centers, after which they re-enter society without medication or assistance for their mental health issues, until the cycle of incarceration recommences.<sup>41</sup>

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30. *Id.*

31. *Id.*

32. *Id.* at 26.

33. *Id.*

34. *Id.*

35. H.R. 6029, 111th Cong. § 101(5) (2010).

36. *Id.* § 101(4).

37. Susan P. Leviton, *Children of Color with Mental Health Problems: Stuck in All the Wrong Places*, 2 MARGINS 13, 26 (2002).

38. Jennifer M. Keys, *When They Need Us Most: The Unaddressed Crisis of Mentally Ill African American Children in the Juvenile Justice System*, 2 DEPAUL J. FOR SOC. JUST. 289, 293-94 (2009); Untress L. Quinn, *The Invisible Child: Disparities in the Mental Health Treatment of the African American Male in the Juvenile Justice System*, CHILD. LEGAL RTS. J., Spring 2008, at 16, 19.

39. See H. Elaine Rodney & H. Richard Tachia, *Over-Representation of Minorities in the Juvenile Justice System: Three Counties in Rural Texas*, FED. PROBATION, Dec. 2004, at 44, 44.

40. Quinn, *supra* note 38, at 20; see also Juvenile Justice and Delinquency Prevention Act of 2002, 42 U.S.C. § 5633(a)(22) (2006) (developing the term disproportionate minority contact); *Disproportionate Minority Contact*, THE SENTENCING PROJECT (May 2010), [http://www.sentencingproject.org/doc/publications/jj\\_DMCfactsheet.pdf](http://www.sentencingproject.org/doc/publications/jj_DMCfactsheet.pdf).

41. See Leviton, *supra* note 37, at 29-31 (explaining that the State of Maryland lacks an

*A. The School System: The Missed Opportunity for Diagnosis and Treatment*

The failure of schools to detect mental health issues in their students has resulted in a school-to-prison pipeline.<sup>42</sup> The public school system was not always like this.<sup>43</sup> In the beginning of the twentieth century, schools were a very nurturing environment.<sup>44</sup> Most schools enrolled forty students per year.<sup>45</sup> But today, the average graduating high school class is over 700 students.<sup>46</sup>

In addition to the changes in size, some legal scholars suggest that the expansion of students' rights has limited discipline options within schools.<sup>47</sup> Many teachers refuse to discipline students for fear of exposing the school to litigation.<sup>48</sup> As a result, many schools rely on law enforcement to discipline students.<sup>49</sup> Consequently, schools have adopted zero-tolerance policies, and "students are being arrested and funneled into the juvenile justice and criminal justice systems for minor incidents at school."<sup>50</sup>

Unfortunately, most of the schools that have zero-tolerance policies are in low-income school districts with a high number of minority students.<sup>51</sup> Many of the students who face the brunt of schools' zero-tolerance policies are minority students suffering from untreated mental health issues.<sup>52</sup> In addition, minority students are suspended at a much

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effective aftercare program for released juvenile offenders).

42. See Kristina Menzel, *The School-to-Prison Pipeline: How Schools Are Failing to Properly Identify and Service Their Special Education Students and How One Probation Department Has Responded to the Crisis*, 15 PUB. INT. L. REP. 198, 199-200 (2010).

43. See Chad Sublet, Note, *Has the Cold Mercy of Custodial Institutionalization Been Supplanted by the Cold Merciless Steel of the Jailhouse?*, 15 KAN. J.L. & PUB. POL'Y 159, 167 (2005).

44. See Jennie Rabinowitz, Note, *Leaving Homeroom in Handcuffs: Why an Over-Reliance on Law Enforcement to Ensure School Safety Is Detrimental to Children*, 4 CARDOZO PUB. L. POL'Y & ETHICS J. 153, 164 (2006); Sublet, *supra* note 43, at 167.

45. Rabinowitz, *supra* note 44, at 164-65.

46. *Id.* at 165.

47. *Id.* ("[T]he United States Supreme Court has recognized that students have a Fourteenth Amendment right to due process before they may be suspended. Students are also protected under the Fourth Amendment against unreasonable searches and seizures.").

48. *Id.* at 166.

49. *Id.* at 169; Editorial, *The Principal's Office First*, N.Y. TIMES, Jan. 5, 2009, at A20 (explaining that over "17,000 police officers patrol school hallways nationwide").

50. Menzel, *supra* note 42, at 200; Sublet, *supra* note 43, at 167.

51. THE SENTENCING PROJECT, *supra* note 40.

52. See Sublet, *supra* note 43, at 167; Charles Hamilton Houston Inst. for Race & Justice, *Coming Together to Dismantle the Cradle to Prison Pipeline in Massachusetts: A Half-Day Summit of Community, Faith and Policy Leaders*, HARV. L. SCH. (Apr. 29, 2010), [http://www.law.harvard.edu/news/2010/06/28\\_edelman.html](http://www.law.harvard.edu/news/2010/06/28_edelman.html).

higher rate than white students.<sup>53</sup> These suspensions are often long-term for minor incidents occurring at school.<sup>54</sup> And many of these minority youth are eligible for special education services.<sup>55</sup> The Individuals with Disabilities Education Act (“IDEA”)<sup>56</sup> is “the primary vehicle for securing mental health services and supports for children and youth with mental, emotional or behavioral disabilities.”<sup>57</sup> Under the IDEA, schools must intervene to address behaviors associated with a student’s disability.<sup>58</sup> Despite this protection, minority students with mental health disorders often go undiagnosed, and are being criminalized instead of receiving the services mandated by the IDEA.<sup>59</sup> In short, schools’ zero-tolerance policies contribute to the DMC issue within the juvenile justice system.<sup>60</sup>

### B. The Warehouse Crisis

Due to the absence of community mental health services, the juvenile justice system warehouses mentally ill children in detention centers.<sup>61</sup> In 2003, a congressional committee conducted a six-month study and determined that nearly fifteen thousand juveniles remained incarcerated because they could not access mental health treatment in their communities.<sup>62</sup> In that same study, seventy-one facilities in thirty-three states found youth who were awaiting community mental health

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53. See Theresa Glennon, *Knocking Against the Rocks: Evaluating Institutional Practices and the African American Boy*, 5 J. HEALTH CARE L. & POL’Y 10, 21 (2002) [hereinafter Glennon, *Institutional Practices and the African American Boy*]; see also Sam Dillon, *Disparities Found in School Suspensions*, N.Y. TIMES, Sept. 14, 2010, at A16 (explaining that “black boys [are] nearly three times as likely to be suspended as white boys”).

54. See Menzel, *supra* note 42, at 200; Charles Hamilton Houston Inst. for Race & Justice, *supra* note 52 (indicating that children as young as five years old are being suspended for behavior that used to be handled by the principal’s office).

55. See Menzel, *supra* note 42, at 200.

56. Individuals with Disabilities Education Act, 20 U.S.C. §§ 1400–1482 (2006). In 2004, the IDEA was amended by the Individuals with Disabilities Education Improvement Act (IDEIA). *Id.* § 1400. However, the Act is still commonly referred to as IDEA. Throughout this Note, the Act will be referred to as IDEA.

57. NAT’L COUNCIL ON DISABILITY, THE WELL BEING OF OUR NATION: AN INTER-GENERATIONAL VISION OF EFFECTIVE MENTAL HEALTH SERVICES AND SUPPORTS (2002), available at <http://www.ncd.gov/publications/2002/Sept162002>.

58. See 20 U.S.C. § 1400(d)(1)(A); Menzel, *supra* note 42, at 198–99.

59. See Sublet, *supra* note 43, at 167.

60. THE SENTENCING PROJECT, *supra* note 40.

61. H. COMM. ON GOV’T REFORM: MINORITY STAFF SPECIAL INVESTIGATIONS DIV., 108TH CONG., INCARCERATION OF YOUTH WHO ARE WAITING FOR COMMUNITY MENTAL HEALTH SERVICES IN THE UNITED STATES 4–7 (2004), available at [http://hsgac.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore\\_id=b77b0508-8a6f-43a0-94df-4dc46ca3658d](http://hsgac.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore_id=b77b0508-8a6f-43a0-94df-4dc46ca3658d) [hereinafter MINORITY STAFF REPORT].

62. *Id.* at 3, 7.

treatment, even though there were no pending charges against them.<sup>63</sup> Even worse, children as young as seven years old were incarcerated because there were no available mental health facilities.<sup>64</sup> As one Oklahoma juvenile detention administrator commented:

To put it simply we are the dumping grounds for the juvenile system. Understand this and understand it well: when the system is unable to get youth placed in a treatment facility or a mental health facility, they will be placed in a detention facility. If a youth needs to be detained in a mental health facility it will not happen; they will be placed in a detention center.<sup>65</sup>

Although this crisis affects all children, the situation is far more tragic among youth of color.<sup>66</sup> The obvious explanation for the increasing rate of minorities in the juvenile justice system is that minority youth commit more serious delinquent acts than whites, but this is not supported by the available research.<sup>67</sup> Simply put, the juvenile justice system has become a “*de facto*” mental health hospital for Black and Latino Americans.<sup>68</sup> Most communities of color lack access to mental health facilities.<sup>69</sup> Even when facilities are available in these communities, they offer poorer quality care.<sup>70</sup> Youth of color are less likely than whites to receive mental health treatment before entering the juvenile justice system.<sup>71</sup> Incidentally, the police often conduct “mercy arrests” since it is easier to treat mentally ill individuals in the juvenile justice system than it is to find them a space in a community mental health facility.<sup>72</sup> As one commentator has noted, “[i]t’s tragic. If you are a young person and mentally ill, you have to get arrested to receive treatment.”<sup>73</sup>

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63. *Id.* at 5. The Special Investigations Division report estimates may be grossly understated because one-quarter of U.S. juvenile detention facilities did not participate in the study. *Id.* at 14.

64. *Id.* at 6.

65. *Id.* at 7 (internal quotation marks omitted).

66. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 26-27.

67. Keys, *supra* note 38, at 295.

68. Leviton, *supra* note 37, at 28.

69. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 27-28.

70. HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 20-21 (2003), available at <http://www.hrw.org/sites/default/files/reports/usa1003.pdf>.

71. See Quinn, *supra* note 38, at 19.

72. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 14; HUMAN RIGHTS WATCH, *supra* note 70, at 21 n.35 (stating “mercy arrests” are a growing phenomenon (internal quotation marks omitted)).

73. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 14 (quoting Judge Hal Gaither of the Dallas County Juvenile Court) (internal quotation marks omitted).



To further complicate matters, many parents will struggle with their children's disorder until there is a major crisis.<sup>74</sup> Desperate parents relinquish custody of their children to the state so their children can receive necessary treatment.<sup>75</sup> The foster care system places some of these children into foster homes while the juvenile justice system warehouses the rest.<sup>76</sup> Basically, "[p]arents of mentally ill youth can be left with essentially only three paths: 'Beat 'em up[,] [l]ock 'em up[, or] [g]ive 'em up.'"<sup>77</sup> Unfortunately, removing children from their families disrupts family relationships.<sup>78</sup> It also further removes parents from the treatment process.<sup>79</sup> In short, the U.S. mental health system is not equipped to meet the needs of minority youth, so instead the juvenile justice system warehouses minority mentally ill youth in detention centers.<sup>80</sup>

### C. Ill-Equipped Facilities

Most juvenile detention centers lack the resources to properly screen or treat a young person with a mental health disorder.<sup>81</sup> These facilities are far from an appropriate place for a mentally ill child.<sup>82</sup> For example, 75% of our nation's juvenile detention centers fail to conform to standard suicide prevention procedures.<sup>83</sup> This number is staggering considering that youth suicide in juvenile detention centers is more than

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74. Leviton, *supra* note 37, at 25.

75. Dennis E. Cichon, *Encouraging a Culture of Caring for Children with Disabilities: A Cooperative Approach*, 25 J. LEGAL MED. 39, 53 (2004); Kasey Corbit, Note, *Inadequate and Inappropriate Mental Health Treatment and Minority Overrepresentation in the Juvenile Justice System*, 3 HASTINGS RACE & POVERTY L.J. 75, 86 (2005); Editorial, *Abandoned Families*, N.Y. TIMES, Nov. 5, 2008, at A34 (explaining that relinquishing custody of a child to the state increases the likelihood that the child will remain in the juvenile justice system). A recent survey illustrated that 23% of parents with a mentally ill child were told by mental health service providers that they had to relinquish custody for their child to receive treatment. Cichon, *supra*.

76. Corbit, *supra* note 75, at 87.

77. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 35.

78. Corbit, *supra* note 75, at 88.

79. *Id.*

80. Leviton, *supra* note 37, at 28; *see also* OFFICE OF THE SURGEON GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL ch. 2, 80 (1999), available at <http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c2.pdf> [hereinafter SURGEON GEN. REPORT].

81. MINORITY STAFF REPORT, *supra* note 61, at 9; *see, e.g., Juvenile Justice Policy Brief Series: Mental Health Issues in California's Juvenile Justice System*, BERKELEY CTR. FOR CRIMINAL JUSTICE, 1, 6, 8 (May 2010), [http://www.law.berkeley.edu/img/BCCJ\\_Mental\\_Health\\_Policy\\_Brief\\_May\\_2010.pdf](http://www.law.berkeley.edu/img/BCCJ_Mental_Health_Policy_Brief_May_2010.pdf) (stating that the California juvenile justice system lacks appropriate mental health assessment tools and treatment within its facilities).

82. MINORITY STAFF REPORT, *supra* note 61, at 10.

83. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 18.

four times the rate of youth suicide in the general population.<sup>84</sup> Even more alarming, one-quarter of the juvenile detention centers holding youth waiting for mental health treatment provide poor quality mental health services, if any at all.<sup>85</sup> According to juvenile justice consultant Paul DeMuro:

It's the most bizarre kind of treatment . . . . In the name of suicide prevention, we lock up a depressed, alienated kid for days on end. When a kid doesn't stand in line, he's a problem. So we restrain him to teach him discipline. But the problem is, that kid can't stand in line. It's part of his illness that he can't stand in line.<sup>86</sup>

Clearly, detention centers are not equipped to be “surrogate mental health centers.”<sup>87</sup> Even when treatment is available, the staff members are not properly trained to deal with mental health issues.<sup>88</sup> Typically, an outside mental health agency provides treatment to youth in detention centers.<sup>89</sup> Rather than receive individual treatment sessions, these youth are normally “seen quickly and en mass.”<sup>90</sup> Furthermore, detention centers have such high turnover rates that it is extremely difficult to administer long-term treatment.<sup>91</sup>

More troubling is that once a youth is in the juvenile justice system, his mental health disorders are exacerbated.<sup>92</sup> In addition, youth entering without preexisting conditions are at a high risk to develop mental health disorders.<sup>93</sup> For example, one academic study reveals that “for one-third of incarcerated youth diagnosed with depression, the onset of the depression occurred after they began their incarceration.”<sup>94</sup> The reason for this is obvious; the facilities are often large, over-crowded, and impersonal.<sup>95</sup> Detained youth often live in constant fear for their safety

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84. *Id.*

85. MINORITY STAFF REPORT *supra* note 61, at 9.

86. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 21 (internal quotation marks omitted).

87. *Id.* at 15.

88. MINORITY STAFF REPORT, *supra* note 61, at 10 (reporting that a Tennessee juvenile administrator commented, “[u]pon admission we screen for mental illness, but the only training we’ve received is a seminar” (internal quotation marks omitted)); COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 15.

89. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 15.

90. *Id.*

91. MINORITY STAFF REPORT, *supra* note 61, at 10.

92. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 24.

93. *Id.* at 25.

94. *The Costs of Confinement: Why Good Juvenile Justice Policies Make Good Fiscal Sense*, JUSTICE POLICY INST., 18 (May 2009), [http://www.justicepolicy.org/images/upload/09\\_05\\_REP\\_CostsOfConfinement\\_JJ\\_PS.pdf](http://www.justicepolicy.org/images/upload/09_05_REP_CostsOfConfinement_JJ_PS.pdf).

95. See COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 24; Leviton, *supra* note 37, at 30.

because of gang activity and aggressive inmates.<sup>96</sup> Many youth are also subject to sexual victimization.<sup>97</sup> Sadly, “[t]hese institutions are extremely ‘criminogenic,’ meaning they create criminals or exacerbate criminal behavior.”<sup>98</sup>

Recent data confirms that youth of color in juvenile detention centers are less likely to undergo screening for mental health disorders.<sup>99</sup> African American males are often underdiagnosed because untrained personnel perceive these youth as “naturally” violent and not mentally ill.<sup>100</sup> Surprisingly, some minority children are over-institutionalized in the mental health system.<sup>101</sup> Research from the 1980s revealed that minority youth were committed to mental health facilities for longer periods than their white counterparts.<sup>102</sup> To be clear, “[b]oth the overutilization and the underutilization of mental health services for this population may be attributable to systemic racial bias in the testing and evaluation of minority youth.”<sup>103</sup> Although juvenile detention centers are normally the only option available for minorities to receive mental health treatment, they often provide minority youth with inadequate treatment, if any at all.<sup>104</sup>

#### D. *The Failed Discharge Plans*

Although there is a national emphasis on aftercare for adult offenders, focus on aftercare for released juveniles is unimpressive.<sup>105</sup> Aftercare plans are normally constructed at the end of a juvenile’s sentence instead of at the beginning.<sup>106</sup> The lack of appropriate discharge plans for mentally ill youth funnels these youth back into the juvenile justice system.<sup>107</sup> A typical discharge plan includes a referral to aftercare

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96. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 24.

97. Keys, *supra* note 38, at 298.

98. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 24.

99. *Id.* at 30.

100. Keys, *supra* note 38, at 306. “While many whites exhibit their emotional disturbances through hurting themselves, some Black children demonstrate their dysfunction by attacking others, which results in the perceived need for incarceration to protect the public.” *Id.*; Quinn, *supra* note 38, at 21.

101. Katherine Hunt Federle & Meda Chesney-Lind, *Special Issues in Juvenile Justice: Gender, Race, and Ethnicity*, in JUVENILE JUSTICE AND PUBLIC POLICY: TOWARD A NATIONAL AGENDA 165, 188 (Ira M. Schwartz ed., 1992).

102. *Id.*

103. *Id.*

104. See Quinn, *supra* note 38, at 19, 21.

105. David M. Altschuler, Essay, *Juvenile Reentry and Aftercare*, 16 GEO. J. ON POVERTY L. & POL’Y 655, 659 (2009).

106. See *id.* at 658; Leviton, *supra* note 37, at 30-31.

107. NAT’L COUNCIL ON DISABILITY, *supra* note 57.

services and a limited amount of medication.<sup>108</sup> In many instances, youth only receive a one-day supply of psychiatric medication upon release.<sup>109</sup> Once juveniles finish the medication they received, they are often unable to continue their medication.<sup>110</sup>

Despite recommendations for continuity of care at community mental health facilities, many minority juveniles cease treatment upon release.<sup>111</sup> One reason for this behavior is that lack of health insurance prevents youth from accessing necessary medications and services upon exit from secure confinement.<sup>112</sup> In fact, over “9 million children nationwide do not have health insurance.”<sup>113</sup> And again, race matters. One-quarter of African Americans nationwide do not have health insurance.<sup>114</sup> Minorities are less likely than their white counterparts to have private health insurance.<sup>115</sup> Although Medicaid fills some of these gaps by providing health insurance to about nearly 50% of children living in low-income households,<sup>116</sup> it does not provide coverage to all low-income children who lack access to mental health services.<sup>117</sup> Further, many state Medicaid programs exclude a range of mental health services.<sup>118</sup> Additionally, most states terminate Medicaid benefits of youth in detention even though there is no federal law requiring states to do so.<sup>119</sup> But at bottom, Medicaid does not completely solve the issue of access to treatment. Youth who are enrolled in Medicaid must navigate through “a complex, confusing patchwork of programs, with fragmented services at the community level.”<sup>120</sup>

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108. N.Y.C. DEP'T OF JUVENILE JUSTICE WITH RESEARCH & EVALUATION CTR. & PRISONER REENTRY INST., JOHN JAY COLL. OF CRIMINAL JUSTICE, THE COLLABORATIVE FAMILY INITIATIVE 11 (2008), available at [http://www.nyc.gov/html/djj/pdf/interim\\_cfi\\_final.pdf](http://www.nyc.gov/html/djj/pdf/interim_cfi_final.pdf) [hereinafter CFI REPORT].

109. Alison Evans Cuellar et al., *Medicaid Insurance Policy for Youths Involved in the Criminal Justice System*, 95 AM. J. OF PUB. HEALTH 1707, 1710 (2005) (reporting that 81% of local juvenile detention centers follow this one-day supply of medication practice).

110. CFI REPORT, *supra* note 108, at 12.

111. *Id.* at 5, 12.

112. See Cuellar et al., *supra* note 109, at 1710.

113. Keys, *supra* note 38, at 308.

114. *Id.*

115. SURGEON GEN. REPORT, *supra* note 80, at 87.

116. CARRIE HANLON ET AL., NAT'L ACAD. FOR STATE HEALTH POLICY, A MULTI-AGENCY APPROACH TO USING MEDICAID TO MEET THE HEALTH NEEDS OF JUVENILE JUSTICE-INVOLVED YOUTH, 6 (2008), available at [http://nashp.org/sites/default/files/Multi\\_Agency\\_NASHP.pdf?q=Files/Multi\\_Agency\\_NASHP.pdf](http://nashp.org/sites/default/files/Multi_Agency_NASHP.pdf?q=Files/Multi_Agency_NASHP.pdf) (explaining that Medicaid provides health coverage for people with limited incomes and resources).

117. NAT'L COUNCIL ON DISABILITY, *supra* note 57.

118. *Id.*

119. See Cuellar et al., *supra* note 109, at 1707.

120. HUMAN RIGHTS WATCH, *supra* note 70, at 21 n.34.

In addition to under-inclusive health insurance coverage, most communities of color lack access to mental health facilities.<sup>121</sup> According to the Office of the Surgeon General, “[r]acial and ethnic minority groups are generally considered to be underserved by the mental health services system.”<sup>122</sup> Even if there are community mental health facilities available, they are ill-equipped to handle the needs of youth with mental health disorders.<sup>123</sup> Even worse, many equipped community mental health facilities refuse to accept a referral from juvenile courts because they fail to recognize juvenile delinquents as mentally ill children.<sup>124</sup>

Furthermore, many mental health facilities that service minority communities do not offer culturally appropriate treatment.<sup>125</sup> “Culturally competent services take into account cross-cultural factors and institutionalize such knowledge” by tailoring services specifically for minority communities.<sup>126</sup> Culturally appropriate facilities are necessary because “mental health disorders . . . manifest themselves differently in different cultures.”<sup>127</sup> Mental health service providers frequently fail to comprehend a youth’s family structure and cultural traditions.<sup>128</sup> More often, mental health services only offer youths of color a short-term treatment plan because they do not account for the “environmental influences on the youth’s delinquent behavior.”<sup>129</sup>

Even when services are available, it can be difficult to get minorities to accept it. In many minority communities, mental health disorders are considered taboo.<sup>130</sup> Blacks and Latinos are often too

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121. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 27-28.

122. SURGEON GEN. REPORT, *supra* note 80, at 80.

123. HUMAN RIGHTS WATCH, *supra* note 70, at 23. A Maine state legislature committee reported that “[c]ommunity mental health services, though very good, are, due to lack of resources, inadequate to meet the needs of persons with mental illness. This has resulted in some persons with mental illness falling through the treatment services net and into the criminal justice system.” *Id.*

124. Gene Griffin & Michael J. Jenuwine, Essay, *Using Therapeutic Jurisprudence to Bridge the Juvenile Justice and Mental Health Systems*, 71 U. CIN. L. REV. 65, 73 (2002).

125. See COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 29.

126. Neelum Arya et al., *America’s Invisible Children: Latino Youth and the Failure of Justice*, CAMPAIGN FOR YOUTH JUSTICE, 55 (May 2009), [http://www.campaignforyouthjustice.org/documents/Latino\\_Brief.pdf](http://www.campaignforyouthjustice.org/documents/Latino_Brief.pdf).

127. Quinn, *supra* note 38, at 19.

128. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 29; Arya et al., *supra* note 126, at 56 (stating that a cultural competence facility would know that many immigrant children live with their extended family members).

129. Brent Pattison, *Minority Youth in Juvenile Correctional Facilities: Cultural Differences and the Right to Treatment*, 16 LAW & INEQ. 573, 582 (1998).

130. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 28 (“In some communities, clinics are seen as being synonymous with the state hospital, which is where ‘crazy’ people are sent.”); see also SURGEON GEN. REPORT, *supra* note 80, at 87 (stating that the stigma of mental illness serves as a barrier for treatment for whites as well).

embarrassed to seek treatment from a mental health facility.<sup>131</sup> Consequently, individuals from minority backgrounds are less likely than whites to receive outpatient mental health treatment.<sup>132</sup> In particular, “African Americans tend to deny the threat of mental illness and strive to overcome mental health problems through self-reliance and determination.”<sup>133</sup> Latinos, on the other hand, often fail to obtain mental health services due to language barriers.<sup>134</sup>

Additionally, religious beliefs prevent many minorities from seeking treatment.<sup>135</sup> Many minorities view mental health disorders as a test of their faith in God.<sup>136</sup> Instead of seeking treatment, they seek guidance from their religious leaders.<sup>137</sup>

Further, before accepting services, many minorities must overcome their deep-rooted distrust of the medical profession.<sup>138</sup> African Americans’ distrust in the health care system traces back to slavery.<sup>139</sup> The Tuskegee syphilis experiment is an example of how Blacks were exploited by the medical profession.<sup>140</sup> For forty years, the U.S. Public Health Service conducted a study on the progression of untreated syphilis in four hundred Black men, in which the cure was withheld from the men.<sup>141</sup> The Tuskegee experiment contributed to Blacks’ skepticism of the medical community.<sup>142</sup> As result, many Blacks do not accept available mental health services.<sup>143</sup> This suspicion has passed from generation to generation.<sup>144</sup>

Other minority groups distrust any “government-operated institutions,” not just the health care system.<sup>145</sup> This is particularly true for undocumented immigrants who may fear that seeking mental health services will lead to deportation.<sup>146</sup> For example, El Salvadorian and

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131. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 28.

132. See SURGEON GEN. REPORT, *supra* note 80, at 87.

133. *Id.*

134. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 28.

135. Keys, *supra* note 38, at 308.

136. See *id.*

137. *Id.*

138. SURGEON GEN. REPORT, *supra* note 80, at 86-87; Keys, *supra* note 38, at 309.

139. Keys, *supra* note 38, at 309.

140. *Id.*

141. *Id.*

142. *Id.* at 309-10.

143. *Id.*

144. See *id.* at 309.

145. SURGEON GEN. REPORT, *supra* note 80, at 87.

146. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 28 (explaining that similar to immigration officers, mental health professionals ask patients to fill out forms with personal information).

Argentine immigrants who have experienced the government murdering their family members may distrust all government institutions.<sup>147</sup>

In short, “[f]ar too often, available treatment does not ‘speak the language’ of a particular culture, both literally and figuratively.”<sup>148</sup> Unfortunately, many discharge plans do not account for these barriers to treatment when releasing minority youth back into their communities.<sup>149</sup> This in turn facilitates a cycle of minority youth re-entering the juvenile justice system as a substitute for mental health treatment.

### *E. Collateral Consequences*

There are substantial collateral consequences to the incarceration of mentally ill youth. Incarceration is a costly solution for youth to receive mental health treatment.<sup>150</sup> Every year, states spend over ten billion dollars on the incarceration of youth in the juvenile justice system.<sup>151</sup> This cost would be more understandable if incarcerated juveniles actually received appropriate treatment.<sup>152</sup> “But here, the law of commerce perversely works in reverse. You don’t get what you pay for.”<sup>153</sup> In fact, 50% to 70% of youth who are previously incarcerated are rearrested within two years of release.<sup>154</sup> This cycle turns into a “costly adult-sized problem[.]”<sup>155</sup> As adults, many of these youth will eventually occupy mental health facilities and local hospitals.<sup>156</sup> Every year, mental health treatment and related services cost taxpayers more than \$150 billion.<sup>157</sup> Sadly, the majority of our tax dollars are not spent on successful solutions—early identification and prevention.<sup>158</sup> In addition,

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147. SURGEON GEN. REPORT, *supra* note 80, at 87.

148. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 28.

149. See Leviton, *supra* note 37, at 31.

150. See COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 23.

151. See *id.* at 23-24 (explaining that a California youth detention center with poor mental health services costs taxpayers \$37,000 a year per youth, which is more than tuition and expenses at some universities); JUSTICE POLICY INST., *supra* note 94, at 8 (estimating that over a twenty-year period the cost of housing one juvenile can be up to \$1.5 million); see also NAACP, MISPLACED PRIORITIES: OVER INCARCERATE, UNDER EDUCATE 13 (2011), available at [http://naacp.3cdn.net/01d6f368edbe135234\\_bq0m68x5h.pdf](http://naacp.3cdn.net/01d6f368edbe135234_bq0m68x5h.pdf) (stating that state spending on prison facilities is the “[s]econd-[f]astest-[g]rowing [p]ublic [i]nvestment”).

152. See COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 24.

153. *Id.*

154. JUSTICE POLICY INST., *supra* note 94, at 16.

155. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 25; Thomas L. Hafemeister, *Parameters and Implementation of a Right to Mental Health Treatment for Juvenile Offenders*, 12 VA. J. SOC. POL’Y & L. 61, 69-70 (2004).

156. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 25.

157. *Id.*

158. *Id.* at 23.

the incarceration of youth in unacceptable conditions has lead to costly litigation for states.<sup>159</sup>

Incarceration imposes a variety of costs on juveniles. Some of these costs have long been obvious, while others have remained invisible.<sup>160</sup> Since “prisons make punishment visible,” society often quantifies prison terms as the only consequence of incarceration.<sup>161</sup> But society also punishes youth offenders in other, less visible ways. These “invisible” consequences have a tremendous impact not only on the juvenile offender, but also his or her family and community.<sup>162</sup> Among other things, incarceration can adversely affect education and employment opportunities.<sup>163</sup> For example, one academic study found that nearly 50% of youth receiving education services in detention facilities did not reenroll in public school after their release.<sup>164</sup> As these statistics demonstrate, incarceration creates “barriers to education and employment that limit . . . [a juvenile offender’s] ability to positively contribute to society.”<sup>165</sup>

Furthermore, collateral consequences affect higher education opportunities for minority youth.<sup>166</sup> For example, youth convicted of a drug-related offense may be ineligible for student loans.<sup>167</sup> This type of consequence disproportionately harms minority youth because of the high rates of minorities incarcerated for drug-related offenses.<sup>168</sup>

In short, incarceration of youth breaks their “transition to adulthood since confinement disrupts natural engagement with families, school, and work.”<sup>169</sup> Released juveniles must overcome significant barriers to ensure a successful return to their communities.<sup>170</sup>

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159. JUSTICE POLICY INST., *supra* note 94, at 7; *see, e.g.*, Stipulation for Injunctive Relief at 35-43, *S.H. v. Stickrath*, No. 2:04-CV-1206 (S.D. Ohio Apr. 9, 2008) (requiring the Ohio Department of Youth Services to improve mental health services within its detention centers); Consent Decree at 6-7, *Farrell v. Allen*, No. RG 03079344 (Cal. Super. Ct. Nov. 8, 2004) (requiring the California Youth Authority to prepare a remedial plan for mental health issues within its facilities).

160. Jeremy Travis, *Invisible Punishment: An Instrument of Social Exclusion*, in *INVISIBLE PUNISHMENT: THE COLLATERAL CONSEQUENCES OF MASS IMPRISONMENT* 15, 15-16 (Marc Mauer & Meda Chesney-Lind eds., 2002) (calling the legal collateral consequences that result from incarceration “invisible punishment”).

161. *Id.* at 15.

162. JUSTICE POLICY INST., *supra* note 94, at 17, 19.

163. *Id.* at 19.

164. *Id.*

165. *Id.*

166. *See* Travis, *supra* note 160, at 31.

167. Higher Education Act of 1965, 20 U.S.C. § 1091(r)(1) (2006).

168. *See* Travis, *supra* note 160, at 31.

169. JUSTICE POLICY INST., *supra* note 94, at 17 (explaining that incarceration slows down the natural “ag[ing] out” of delinquent . . . behavior”).

170. *Id.* at 17, 19; Sharon Dolovich, *Foreword: Incarceration American-Style*, 3 HARV. L. &



### III. ACCOUNTABILITY FOR THE WAREHOUSE CRISIS

Several legislative and administrative policies have contributed to the warehouse crisis.<sup>171</sup> Far too often, state systems deny their responsibility to mentally ill children by asserting that another system should be providing them with mental health services.<sup>172</sup> This Note identifies and analyzes each systems' legal responsibility to end the warehouse crisis.<sup>173</sup>

#### A. *The Forgotten "IDEA"*

Detecting mental health disorders in students is the first step in ending the school-to-prison pipeline.<sup>174</sup> As previously stated, the IDEA requires schools to provide a Free Appropriate Public Education ("FAPE") to every student with a disability.<sup>175</sup> The Act was passed based on findings that millions of children in the United States with disabilities were not provided with special education services.<sup>176</sup> Additionally, Congress found that many students with disabilities were excluded from the school system, while others were allowed to participate but did not realize the full benefits of an education because their disabilities were undetected.<sup>177</sup> Under the IDEA, children with mental disorders are entitled to special education services,<sup>178</sup> including any related mental health services that enable them to receive a FAPE.<sup>179</sup> The IDEA describes the indicators of mental health disorders under the definition of "emotional disturbance,"<sup>180</sup> which is defined as:

[A] condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:

(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.

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POL'Y REV. 237, 248 (2009) ("Given the 'learned passivity' that comes with a total loss of control over one's life, it is not to be wondered if those who have served their time are unable to take the steps required to build a successful post-prison existence." (footnote omitted)).

171. See *infra* Part III.

172. See HANLON ET AL., *supra* note 116, at 8; Sublet, *supra* note 43, at 179.

173. See *infra* Part III.

174. See Menzel, *supra* note 42, at 200; Sublet, *supra* note 43, at 167.

175. Individuals with Disabilities Education Act, 20 U.S.C. § 1400(d)(1)(A) (2006).

176. *Id.* § 1400(c)(2)(A).

177. *Id.* § 1400(c)(2)(B)–(C).

178. Menzel, *supra* note 42, at 199; Julia C. Dimoff, Comment, *The Inadequacy of the IDEA in Assessing Mental Health for Adolescents: A Call for School-Based Mental Health*, 6 DEPAUL J. HEALTH CARE L. 319, 329 (2003).

179. 20 U.S.C. § 1400(d)(1)(A).

180. Dimoff, *supra* note 178, at 329 (internal quotation marks omitted).

- (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
- (C) Inappropriate types of behavior or feelings under normal circumstances.
- (D) A general pervasive mood of unhappiness or depression.
- (E) A tendency to develop physical symptoms or fears associated with personal or school problems.<sup>181</sup>

This definition does not illustrate how acute these characteristics must be in a student or how much these characteristics must interfere with a student's educational performance in order for a student to be eligible for related services under the IDEA.<sup>182</sup> Consequently, decisions on which students are referred for related services are highly subjective.<sup>183</sup>

For example, the IDEA's definition of emotional disturbance excludes students considered "socially maladjusted."<sup>184</sup> This behavior has been characterized as a repeated pattern of "violating societal norms."<sup>185</sup> As discussed above, the IDEA also defines emotional disturbance as "[i]nappropriate types of behavior or feelings under normal circumstances."<sup>186</sup> The definitions for socially maladjusted and emotional disturbance are nearly indistinguishable.<sup>187</sup> Without an explanation of the law, untrained teachers are left to determine the difference between the terms.<sup>188</sup> Sadly, "a definitional interpretation can make the difference between a child who receives services, and one who does not."<sup>189</sup>

Another problem with the IDEA is its failure to account for systemic racial bias in the diagnosis of minority youth with mental disorders.<sup>190</sup> Outside of the school setting, psychologists frequently misdiagnose minority youth because their behavior seems "threatening," as opposed to a "cry" for mental health treatment.<sup>191</sup> But this result is

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181. Assistance to States for the Education of Children with Disabilities, 34 C.F.R. § 300.8(c)(4)(i)(A)–(E) (2009).

182. Dimoff, *supra* note 178, at 330.

183. *Id.*

184. 34 C.F.R. § 300.8(c)(4)(ii).

185. See Menzel, *supra* note 42, at 201.

186. 34 C.F.R. § 300.8(c)(4)(i)(C).

187. Dimoff, *supra* note 178, at 332.

188. *Id.* at 330.

189. *Id.* at 332.

190. Keys, *supra* note 38, at 307; Quinn, *supra* note 38, at 20.

191. Quinn, *supra* note 38, at 19-20 ("There is a general opinion that when an African American child commits a crime, it is casually interpreted as a normal occurrence for African Americans.").

also true within schools. Under the IDEA, schools have severe problems with the evaluation of minority students with mental disorders.<sup>192</sup>

The IDEA relies on the assumption that because “disabilities have an objectively discernable nature, race does not influence their identification.”<sup>193</sup> This places great trust in the individuals referring students for services.<sup>194</sup> However, research indicates that individual bias in labeling students of color has resulted in an overwhelming number of Black students in the juvenile justice system in comparison to their white counterparts.<sup>195</sup> In reality, what should be an objective evaluation of a child’s behavior is a subjective interpretation based on a teacher’s individual bias.<sup>196</sup>

Studies revealing the disproportionate use of school suspensions of minority students are equally troubling.<sup>197</sup> Scholars have discovered “systemic racial discrimination” in school suspensions.<sup>198</sup> And when schools do not discipline students themselves, their reliance on law enforcement to discipline students has contributed to the disproportionate number of minority youth with mental disorders in the juvenile justice system.<sup>199</sup>

If, however, schools followed the guidelines under the IDEA, minority students would be diverted from the juvenile justice system.<sup>200</sup> If a student is identified in school as having a mental health disorder, the IDEA requires the school to create an Individualized Education Plan (“IEP”).<sup>201</sup> An IEP is “a written statement for each child with a disability that is developed, reviewed, and revised.”<sup>202</sup> In developing the IEP, the parents of the student, the student’s teacher, and other specialists (the “IEP Team”),<sup>203</sup> must balance the student’s educational goals and mental health needs.<sup>204</sup> If a special education student misbehaves, schools may not automatically invoke their zero-tolerance policies; instead the IDEA mandates that schools determine if a child’s misconduct is a

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192. Dimoff, *supra* note 178, at 336.

193. Theresa Glennon, *Race, Education, and the Construction of a Disabled Class*, 1995 Wis. L. REV. 1237, 1242 [hereinafter Glennon, *Race and Education*].

194. *Id.*

195. See Quinn, *supra* note 38, at 20.

196. Dimoff, *supra* note 178, at 338.

197. Dillon, *supra* note 53, at A16.

198. Glennon, *Institutional Practices and the African American Boy*, *supra* note 53, at 22.

199. See Rabinowitz, *supra* note 44, at 171.

200. Sublet, *supra* note 43, at 167.

201. Individuals with Disabilities Education Act, 20 U.S.C. § 1414(d)(1)(A)(i) (2006); Glennon, *Race and Education*, *supra* note 193, at 1248.

202. 20 U.S.C. § 1414(d)(1)(A)(i).

203. *Id.* § 1414(d)(1)(B).

204. See *id.* § 1414(d)(1)(A)(i)(I), (IV).

manifestation of his or her disability.<sup>205</sup> If the misconduct is not a manifestation of the child's disability, the student may be disciplined like any other student.<sup>206</sup> But, if the behavior is found to be a manifestation of the student's disability, the student cannot be removed from the school.<sup>207</sup>

However, the IDEA does allow schools to report crimes to the local authorities.<sup>208</sup> Once the authorities are called, schools must render the student's IEP and disciplinary records.<sup>209</sup> Far too often, the police arrest students at school without asking if the strategies for behavioral intervention under their IEP have been followed.<sup>210</sup> Even worse, many juvenile courts do not intervene when the school does not follow the behavioral intervention strategies under the student's IEP.<sup>211</sup> Without a juvenile defense attorney who is aware of the array of special education services through the IDEA, students with mental disorders may face the harsh reality of entering the juvenile justice system.<sup>212</sup>

Notwithstanding being disproportionately placed in special education, minority students are less likely than white students to receive all the available special education services under the IDEA.<sup>213</sup> Unfortunately, many schools do not administer IEPs.<sup>214</sup> Many school officials confess that "they don't understand the statute; others are ignoring or actively subverting the law. In almost all cases, it is apparent that school personnel are unaware of how effective (and relatively inexpensive) these interventions can be."<sup>215</sup>

In short, the IDEA lacks an appropriate enforcement scheme.<sup>216</sup> Schools are not held accountable for their failure to provide a FAPE for mentally ill students.<sup>217</sup> Too often, schools escape responsibility by relying on law enforcement.<sup>218</sup> As observed by scholar Jonathan Simon:

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205. *Id.* § 1415(k)(1)(E)(i); Joseph B. Tulman & Douglas M. Weck, *Shutting Off the School-to-Prison Pipeline for Status Offenders with Education-Related Disabilities*, 54 N.Y.L. SCH. L. REV. 875, 889 (2009-2010).

206. 20 U.S.C. § 1415(k)(1)(C); Tulman & Weck, *supra* note 205, at 889.

207. 20 U.S.C. § 1415(k)(1)(F)(iii).

208. *Id.* § 1415(k)(6)(A); Menzel, *supra* note 42, at 203.

209. 20 U.S.C. § 1415(k)(6)(B); Menzel, *supra* note 42, at 203.

210. *See* Tulman & Weck, *supra* note 205, at 898, 900.

211. *See id.* at 906.

212. *See id.*

213. *See* Glennon, *Institutional Practices and the African American Boy*, *supra* note 53, at 20-21.

214. NAT'L COUNCIL ON DISABILITY, *supra* note 57.

215. *Id.*

216. *See supra* text accompanying notes 188-89, 208-15.

217. *See* NAT'L COUNCIL ON DISABILITY, *supra* note 57.

218. *See supra* text accompanying notes 48-60, 208-11.

If schools today are again coming to seem more and more like prisons, it is not because of a renewed faith in the capacity of disciplinary methods. Indeed, prisons and schools increasingly deny their capacity to do much more than sort and warehouse people. What they share instead is the institutional imperative that crime is simultaneously the most important problem they have to deal with and a reality whose “existence”—as defined by the federally imposed edict of ever-expanding data collection—is precisely what allows these institutions to maintain and expand themselves in perpetuity.<sup>219</sup>

Sadly, many schools have forgotten the “idea” of early intervention and prevention.<sup>220</sup> Instead, schools provide students with the “preferred” treatment choice of incarceration.<sup>221</sup>

*B. Ineffective Federal Laws to Address the Warehouse Crisis in the Juvenile Justice System*

For many special education eligible students swept into the school-to-prison pipeline, incarceration in a juvenile detention center is a tragic stint in a correctional warehouse filled with untreated mentally ill minority youth.<sup>222</sup> The simple fact is that federal laws do not sufficiently protect mentally ill youth from being warehoused in the juvenile justice system.<sup>223</sup> In 1974, Congress passed the Juvenile Justice and Delinquency Prevention Act (“JJDP”) to provide authority on the deinstitutionalization of status youth offenders in the juvenile justice system.<sup>224</sup> In order to receive a federal grant under the JJDP, states were required to remove status youth offenders from juvenile detention centers and relocate them to community-based facilities.<sup>225</sup> Despite this seemingly successful effort to create a federal law to deinstitutionalize the juvenile justice system, the fact remains that juvenile detention centers have become a “*de facto*” mental health hospital for minority youth with mental health disorders.<sup>226</sup> Ironically, the deinstitutionalization movement “may have inadvertently created bed

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219. JONATHAN SIMON, GOVERNING THROUGH CRIME: HOW THE WAR ON CRIME TRANSFORMED AMERICAN DEMOCRACY AND CREATED A CULTURE OF FEAR 231 (2007).

220. See *supra* text accompanying notes 48-60, 208-11.

221. See *supra* text accompanying notes 48-60, 208-11.

222. See Menzel, *supra* note 42, at 199-200.

223. See *supra* Part III.A; see *infra* text accompanying notes 227-60.

224. Juvenile Justice and Delinquency Prevention Act of 2002, 42 U.S.C. §§ 5601–5792a (2006).

225. BARRY C. FELD, BAD KIDS: RACE AND THE TRANSFORMATION OF THE JUVENILE COURT 173 (1999).

226. *Id.* at 175.

227. Leviton, *supra* note 37, at 28; see *supra* Part II.B.

space in . . . [detention centers] that was immediately filled by minority youths placed by a juvenile justice system that [was] ‘getting tough’ on juvenile crime.”<sup>228</sup> Additionally, many state juvenile codes allow youth offenders to be prosecuted as adults.<sup>229</sup> Sadly, juvenile sentencing is usually offense oriented instead of treatment based.<sup>230</sup> This helps continue the incarceration cycle.<sup>231</sup>

The JJDPa also required states to address racial disparities within secure confinement.<sup>232</sup> Amendments to the JJDPa have broadened the scope to disproportionate minority *contact* related to all stages of the juvenile justice system.<sup>233</sup> Under the current JJDPa, states are required to “address juvenile delinquency prevention efforts and system improvement efforts designed to reduce, without establishing or requiring numerical standards or quotas, the disproportionate number of juvenile members of minority groups, who come into contact with the juvenile justice system.”<sup>234</sup>

Unfortunately, this mandate does not indicate how states should comply with the DMC reduction requirement.<sup>235</sup> As a result, states use various methods to comply with the DMC reduction mandate.<sup>236</sup> But far too often, states decline to provide culturally competent treatment to juvenile offenders to reduce the racial disproportion in confinement.<sup>237</sup> However, there has been increased attention to the importance of culturally competent treatment as a few states have changed their juvenile code to integrate cultural appropriate programming for confined juveniles.<sup>238</sup> But on the federal level there is no mandate to provide culturally competent treatment for minority youth offenders.<sup>239</sup>

Even worse, under the JJDPa, there is no federal mandate to provide “appropriate” mental health treatment.<sup>240</sup> Indeed, the JJDPa requires states, as a condition of receiving federal funding, to prepare “a plan for providing needed mental health services to juveniles in the

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228. Federle & Chesney-Lind, *supra* note 101, at 166.

229. Pattison, *supra* note 129, at 575.

230. *See id.*

231. *See id.*

232. Quinn, *supra* note 38, at 21.

233. *See* Juvenile Justice and Delinquency Prevention Act of 2002, 42 U.S.C. § 5633(a)(22) (2006).

234. *Id.*

235. *See id.*

236. *See* Quinn, *supra* note 38, at 21.

237. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 29-30.

238. Pattison, *supra* note 129, at 580.

239. *See* 42 U.S.C. § 5633(a)(22).

240. *See id.* § 5633(a)(9)(S).

juvenile justice system.”<sup>241</sup> But again, the statute lacks a specific standard for the plan.<sup>242</sup> At the core of this federal requirement there is no emphasis on early assessment or culturally appropriate mental health treatment.<sup>243</sup> Without early assessment, youth with mental health disorders remain unnoticed in an over-crowded juvenile detention center.<sup>244</sup> Despite the Office of Juvenile Justice and Delinquency Prevention’s recommendation to have mandatory mental health screenings on juveniles, doctors only screen 61% of offenders for mental health disorders.<sup>245</sup>

Another problem with the JJDPa is that it does not sanction states for neglecting to provide and implement a plan for “appropriate” mental health services to juvenile offenders.<sup>246</sup> This serves as an incentive to provide subpar mental health services. Because there is no national standard for what appropriate mental health treatment should consist of for juveniles,<sup>247</sup> most state governments only provide appropriate mental health services after an investigation or lawsuit is brought by the Department of Justice (“DOJ”) under the Civil Rights of Institutionalized Persons Act (“CRIPA”).<sup>248</sup>

Under CRIPA, the DOJ has the authority to investigate conditions in detention centers to protect the safety and health of juveniles.<sup>249</sup> A CRIPA action begins with the DOJ’s discovery of possible civil rights violations at a detention center.<sup>250</sup> These allegations are usually received from media reports, letters from prisoners, or information from former employees of the juvenile detention center.<sup>251</sup> Many of the DOJ’s investigations into detention centers end in consent decrees<sup>252</sup> requiring

241. *See id.* § 5633(a)(7)(B)(iv).

242. *See id.*

243. *See id.* § 5633(a)(9)(S); Quinn, *supra* note 38, at 22.

244. *See* COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 15.

245. Keys, *supra* note 38, at 300.

246. *See* 42 U.S.C. § 5633(c) (providing that if a state fails to implement a mental health services plan, there is at least a 20% decrease in its federal grant).

247. *See supra* text accompanying notes 240-43.

248. *See* Civil Rights of Institutionalized Persons Act, 42 U.S.C. §§ 1997-1997j (1996); S. REP. NO. 96-416, at 18-19 (1979), *reprinted in* 1980 U.S.C.C.A.N. 787, 799-800.

249. 42 U.S.C. § 1997a(a); S. REP. NO. 96-416, at 17-19, *reprinted in* 1980 U.S.C.C.A.N. at 799; *see, e.g.,* Nicholas Confessore, *State Agreeing to Big Changes at Youth Jails: Federal Oversight and Staff for Mentally Ill*, N.Y. TIMES, July 15, 2010, at A1 (explaining that the DOJ will take control of New York’s juvenile justice system unless the state reforms the available mental health services at four juvenile detention centers).

250. 42 U.S.C. § 1997a(a).

251. Stephanie Hu, *NJDC Fact Sheet: Using the Civil Rights of Institutionalized Persons Act to Protect Detained and Incarcerated Youth*, NAT’L JUVENILE DEFENDER CTR., <http://www.njdc.info/pdf/factsheetCRIPA.pdf> (last visited Nov. 11, 2011).

252. BLACK’S LAW DICTIONARY 471 (9th ed. 2009) (defining consent decree as “[a] court decree that all parties agree to”).

the state to take certain corrective actions.<sup>253</sup> The DOJ monitors the juvenile detention center's compliance with the requirements of the decree.<sup>254</sup> Although CRIPA investigations are effective, the DOJ investigates a limited number of detentions per year.<sup>255</sup> This is due in part to the fact that the DOJ rarely receives complaints from juvenile offenders or their families.<sup>256</sup> Most juveniles and their families are unaware of the remedial actions under CRIPA.<sup>257</sup> By the time the DOJ performs an investigation, children like Kheil Coppin have already slipped through the cracks.

In short, the JJDPa lacks an appropriate enforcement scheme.<sup>258</sup> Beyond compliance with consent decrees, states lack laws that strengthen the enforcement of the JJDPa or protect the health of juvenile offenders.<sup>259</sup> Without federal enforcement, state governments do little to address the issue of their juvenile detention centers becoming "surrogate mental health centers."<sup>260</sup>

### C. *The Prison Cycle*

In order to lower the recidivism<sup>261</sup> rates of released juvenile offenders with mental health disorders, the U.S. mental health system must develop effective aftercare.<sup>262</sup> Unfortunately, there is insufficient legislation addressing discharge plans for mentally ill youth released from the juvenile justice system.<sup>263</sup>

As noted earlier, recently released juveniles in need of mental health services are left to their own devices to obtain appropriate treatment.<sup>264</sup> In many communities of color, availability of mental health services for children is nonexistent.<sup>265</sup> This is a result of the Community Mental Health Centers Act of 1963 ("CMHCA"), which authorized the closing of large state mental health hospitals but, consequently, ceased

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253. Hu, *supra* note 251.

254. *Id.*

255. *See id.*

256. *Id.*

257. *Id.*

258. *See supra* text accompanying notes 235-48.

259. *See* Quinn, *supra* note 38, at 22.

260. *See* S. REP. NO. 96-416, at 19 (1979), *reprinted in* 1980 U.S.C.C.A.N. 787, 800; COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 15.

261. BLACK'S LAW DICTIONARY, *supra* note 252, at 1384 (defining recidivism as "[a] tendency to relapse into a habit of criminal activity or behavior").

262. *See* Altschuler, *supra* note 105, at 658-59.

263. *See* ANTHONY C. THOMPSON, *RELEASING PRISONERS, REDEEMING COMMUNITIES: REENTRY, RACE, AND POLITICS* 89 (2008); Altschuler, *supra* note 105, at 659.

264. *See supra* Part.II.D.

265. COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 28.



service of individuals with mental health disorders in their community.<sup>266</sup> The CMHCA was extremely successful in closing state hospitals,<sup>267</sup> however, it failed to construct new community mental health centers.<sup>268</sup> Like in 1963, the community mental health systems are still described as “fragmented, underfunded, and in general disrepair.”<sup>269</sup>

Additionally, as stated previously, even when there are available community mental health services, minority youth with mental health disorders rarely continue treatment upon exit from secure confinement.<sup>270</sup> One of the reasons for this is that the JJDPa does not require juvenile detention staff to prepare discharge plans.<sup>271</sup> Far too often, juvenile detention staff members fail to adequately prepare a discharge plan for youth to continue treatment.<sup>272</sup> In addition, there is no federal law prohibiting community mental health facilities from refusing to accept the intake of a referral from juvenile court.<sup>273</sup>

Even worse, many youth of color lack health insurance, which prevents youth from accessing necessary medications and services upon release from the detention centers.<sup>274</sup> Title XIX of the Social Security Act established Medicaid as an insurance program to be administered by the states but within federal guidelines.<sup>275</sup> The Medicaid system is crucial in providing youth with access to quality mental health services, but there are limitations on services provided to incarcerated youth.<sup>276</sup> Under the existing law, federal Medicaid funds may not be used to pay for health care services to “inmate[s] of a public institution.”<sup>277</sup> However, federal law does not require states to terminate Medicaid during a juvenile’s period of incarceration.<sup>278</sup> Nevertheless, most juvenile detention center personnel terminate Medicaid benefits of youth.<sup>279</sup>

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266. Sublet, *supra* note 43, at 162-63.

267. *Id.* at 162.

268. *Id.* at 163 (explaining that less than 25% of the promised 2000 community mental health facilities were built).

269. *Id.*

270. See CFI REPORT, *supra* note 108, at 12.

271. See Juvenile Justice and Delinquency Prevention Act of 2002, 42 U.S.C. § 5633(a)(7)(B)(iv) (2006).

272. See Leviton, *supra* note 37, at 31.

273. See Griffin & Jenuwine, *supra* note 124, at 73.

274. See *supra* text accompanying notes 112-20.

275. HANLON ET AL., *supra* note 116, at 6-7.

276. *Id.*

277. Social Security Act, 42 U.S.C. § 1396d(a)(28)(A) (2006).

278. Cuellar et al., *supra* note 109, at 1707.

279. *Id.* at 1709.

Termination of Medicaid normally occurs because prison personnel do not understand the Medicaid laws.<sup>280</sup> In addition, there is no federal law prohibiting states from terminating Medicaid benefits for youth enrolled in Medicaid prior to their detention.<sup>281</sup> Of course, termination is not the only problem. Even when there is no termination, there is little effort by prison personnel to enroll youth in Medicaid upon release.<sup>282</sup> Without access to health insurance and appropriate mental health facilities, mentally ill minority youth will reenter the juvenile justice system, finding themselves stuck in a hopeless cycle.<sup>283</sup>

#### IV. RECOMMENDATIONS

Unfortunately, there is no one solution to end incarceration as the “preferred” treatment choice for minority children with mental health disorders.<sup>284</sup> Scholars have cited early prevention as the key solution.<sup>285</sup> Although this suggestion is an important one, it does not go nearly far enough. Below, this Note outlines a comprehensive plan for ending the school-to-prison pipeline and the warehousing of youth in the juvenile justice system.

##### A. Early Prevention

The IDEA’s policy of providing mental health services to students within the school system is positive on its face, but flawed in its implementation.<sup>286</sup> Many mentally ill minority students do not receive the services that they are entitled to under the IDEA.<sup>287</sup> This is due in part to the fact that the IDEA lacks specific guidelines on how to prevent the school-to-prison pipeline for minority students.<sup>288</sup> The IDEA should be amended to require states to reduce the disproportionate use of suspension and referrals to law enforcement against minorities with mental health disorders. The JJDPa already requires states to address the DMC issue within the juvenile justice system;<sup>289</sup> however, schools do not have a legal obligation to reduce the DMC issue in the school

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280. See HANLON ET AL., *supra* note 116, at 8.

281. See Cuellar et al., *supra* note 109, at 1707.

282. See *id.* at 1710.

283. See *supra* Part II.D.

284. Sublet, *supra* note 43, at 180.

285. See Quinn, *supra* note 38, at 22.

286. See *supra* Part III.A.

287. See *supra* Part III.A.

288. See Individuals with Disabilities Education Act, 20 U.S.C. §§ 1400–1482 (2006); *supra* Part III.A.

289. See *supra* text accompanying notes 232–34.

discipline context.<sup>290</sup> This proposed amendment would require schools to end the unnecessary criminalization of minority students and create alternative discipline procedures.

The IDEA should also be amended to require schools to have a mental health professional on site.<sup>291</sup> The mental health professional should observe each class within the school on a rotational basis. Since many teachers fail to identify children with mental health disorders,<sup>292</sup> an on site mental health professional can fill this gap. Although this will probably not eradicate the systemic racial bias in referring students for services, mental health professionals should be educated on the differences in the manifestation of symptoms of certain mental illnesses in minorities.<sup>293</sup> Thus, having a professional evaluate students will likely lead to more efficient recognition and diagnosis of mental illness in minority youth. There should also be federal regulations clarifying the definitional difference between emotional disturbance and socially maladjusted.<sup>294</sup> This would provide mental health professionals and teachers guidance on which students to refer for services.<sup>295</sup>

In addition, to increase the school's accountability for mentally ill youth, states should amend juvenile court rules to require that a pretrial conference must be scheduled for all students referred to the court by their school for a non-violent crime.<sup>296</sup> At the pretrial conference, a court counselor will discuss the case with the juvenile's defense attorney, the district attorney, and a school district representative.<sup>297</sup> The school representative must provide all behavioral and educational documentation, including IEP reports. If the court counselor learns that the IEP behavioral strategy has not been followed, the court should dismiss the case and order the school to implement the IEP.<sup>298</sup> Although a defense attorney should notify the court if his or her client's IEP has

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290. See 20 U.S.C. § 1415(k).

291. See Ellen A. Callegary, *The IDEA's Promise Unfulfilled: A Second Look at Special Education & Related Services for Children with Mental Health Needs After Garret F.*, 5 J. HEALTH CARE L. & POL'Y 164, 199 (2002) (stating that IEPs should specify service hours for mental consultations).

292. See *supra* text accompanying notes 188-99.

293. See *supra* text accompanying notes 190-96.

294. See Menzel, *supra* note 42, at 205; *supra* text accompanying notes 182-89.

295. See *supra* text accompanying notes 182-89.

296. See PRO BONO COMM., MULTNOMAH BAR ASS'N YOUNG LAWYERS SECTION, YOUTH FACES THE LAW: A JUVENILE RIGHTS HANDBOOK 36 (11th ed. 2011) (stating that some counties in Oregon require pretrial conferences to be scheduled in juvenile cases); see, e.g., MINN. JUVENILE CT. R. 11.01, available at [http://www.revisor.mn.gov/data/revisor/court\\_rules/ju/\\_2011-08-04\\_11-57-31/ju\\_chapter.pdf](http://www.revisor.mn.gov/data/revisor/court_rules/ju/_2011-08-04_11-57-31/ju_chapter.pdf) (stating that a juvenile court has the discretion to order a pretrial conference).

297. See PRO BONO COMM., *supra* note 296, at 36.

298. See Tulman & Weck, *supra* note 205, at 902.

not been followed, many attorneys are unaware of the available services under the IDEA.<sup>299</sup> Instead of relying on a juvenile defense attorney's advocacy skills, the school should be required to prove that it followed the IEP guidelines. These recommendations will decrease school administrators' reliance on their zero-tolerance policies and hold them accountable for implementing IEPs.

### B. Increasing Community Assistance

Early prevention also requires increased community awareness and assistance.<sup>300</sup> Far too often, minority parents are not aware of the need for early identification and intervention of mental illness.<sup>301</sup> Schools within communities of color should have Parent Teacher Association meetings to educate parents on the signs of mental health disorders and treatment options.<sup>302</sup> Parents should also be informed that they may request that the school perform an initial evaluation of their child for a determination of eligibility for special education services.<sup>303</sup> In addition, schools should offer bilingual meetings and literature on mental health issues.<sup>304</sup> In order to dispel cultural stigmas about mental health treatment, the Department of Health should run advertisements in communities of color about mental health testing and treatment.<sup>305</sup>

Moreover, the federal government and state legislatures must increase funding for community-based mental health organizations so children can receive help within their communities instead of entering the juvenile justice system.<sup>306</sup> Parents should not have to relinquish custody of their children to receive needed mental health services.<sup>307</sup>

### C. The Missouri Approach

As for the warehousing of mentally ill children in juvenile detention centers, many scholars have suggested that community and evidence-

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299. *See id.*

300. Quinn, *supra* note 38, at 22.

301. *See id.*

302. *See id.*

303. Individuals with Disabilities Education Act, 20 U.S.C. § 1414(a)(1)(B) (2006).

304. *See* COAL. FOR JUVENILE JUSTICE, *supra* note 25, at 28 (explaining that language barriers are often a reason why Latinos do not seek mental health services).

305. *See, e.g.,* Mireya Navarro, *Group Begins New AIDS Ads in Subways*, N.Y. TIMES, Jan. 14, 1994, at B3 (explaining that New York City's Department of Health posted H.I.V. prevention advertisements on subway cars to increase awareness of the disease).

306. *See supra* text accompanying notes 264-69.

307. *See supra* text accompanying notes 74-79.

based programs will reduce the number of youth in detention centers.<sup>308</sup> As noted by juvenile justice scholar Barry Feld:

Typically, positive treatment effects occur in small experimental programs that provide an intensive and integrated response to the multiplicity of problems—educational deficits; family dysfunction; inadequate interpersonal, social, and vocational skills; and poverty—that delinquent youths present. Generally, the most positive treatment effects occur only under optimal conditions, such as high treatment integrity in an established program with services provided by mental health or other nonjuvenile justice correctional personnel.<sup>309</sup>

The Missouri Division of Youth Services has constructed a national model for community-based programs.<sup>310</sup> Unlike the traditional juvenile offender route, youth are placed in residential homes.<sup>311</sup> This setting allows for individualized treatment.<sup>312</sup>

Data proves that the Missouri approach is successful.<sup>313</sup> Missouri has a 10% recidivism rate, which is relatively low in comparison to other states.<sup>314</sup> Most state juvenile justice systems have a recidivism rate of higher than 50%.<sup>315</sup> Under the Missouri program blueprint, minority youth would receive appropriate mental health treatment in a “more personal setting.”<sup>316</sup> Lastly, Missouri’s program makes fiscal sense. On average, Missouri taxpayers spend about \$109,791 per day on treating juvenile offenders, compared to North Carolina’s cost of \$210,648 to warehouse youth.<sup>317</sup>

Despite the proven success of the Missouri community-based services program, many states refuse to adopt a similar approach.<sup>318</sup> Instead, state juvenile detention centers remain over-crowded and ill-equipped to provide mental health treatment to juvenile offenders.<sup>319</sup> Given the availability of this solution, this is unacceptable. States should be required to create community-based services for mentally ill juvenile offenders. Under the Eighth Amendment’s cruel and unusual punishment clause, states cannot intentionally deny juvenile offenders access to

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308. See FELD, *supra* note 225, at 281-82; Keys, *supra* note 38, at 312-13.

309. FELD, *supra* note 225, at 282 (citation omitted).

310. Keys, *supra* note 38, at 313.

311. *Id.* at 312.

312. *Id.* at 313.

313. *Id.*

314. *Id.*

315. *Id.*

316. *Id.*

317. JUSTICE POLICY INST., *supra* note 94, at 4.

318. See H.R. 6029, 111th Cong. § 101(12), (16) (2010).

319. See *supra* Part II.C.

mental health services and treatment.<sup>320</sup> The overcrowding of a facility may be used as evidence of intentional denial of access to care.<sup>321</sup> If a court determines that overcrowding in a juvenile detention center is the primary reason for the inadequate provision of mental health services, the court should issue a prison release order.<sup>322</sup> The order should require the release of all mentally ill status offenders within the state's detention centers over a period of one year. In order to comply with this injunction, states should construct residential facilities for treatment of these youth.<sup>323</sup> This will inevitably reduce the number of detained mentally ill minority youth in detention centers and encourage states to adopt the Missouri blueprint.

#### D. Reauthorization of the JJDP

The JJDP is long overdue for reauthorization. During the 111th Congress, reauthorization bills were introduced in both the House of Representatives and Senate.<sup>324</sup> However, these bills did not become law.<sup>325</sup> The JJDP should be reauthorized to create federal standards for improving mental health services and developing aftercare plans.<sup>326</sup> The previous bills should serve as a guidepost for the reauthorization.

The JJDP should require states to ensure that juveniles held in confinement for more than twenty-four hours receive mental health assessments.<sup>327</sup> Early assessment allows a juvenile to receive needed treatment before his or her disorder exacerbates.<sup>328</sup> However, many juvenile detention centers do not have trained mental health professionals on site to conduct early assessments.<sup>329</sup> For example, New York's juvenile detention centers do not have a single full-time psychiatrist on staff.<sup>330</sup> In order to address staffing issues, states should

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320. Quinn, *supra* note 38, at 23.

321. See, e.g., *Brown v. Plata*, 131 S. Ct. 1910, 1923, 1947 (2011) (holding that the overcrowding conditions in the California adult prison system violated the Eighth Amendment's ban on cruel and unusual punishment).

322. A prison release order should only be granted after a state fails to comply with a less intrusive court order. See *id.* at 1923, 1929.

323. See *id.* at 1929.

324. See, e.g., H.R. 6029, 111th Cong. (2010); S. 678, 111th Cong. (2009).

325. A bill is only available throughout an entire Congress. *Frequently Asked Questions*, THOMAS, <http://thomas.loc.gov/home/faqlist.html> (last visited Nov. 11, 2011). If a bill has not been acted on by the end of a Congress, it would have to be reintroduced in a succeeding Congress for consideration. *Id.*

326. See *supra* text accompanying notes 240-48, 270-71.

327. H.R. 6029 § 205(1)(S)(32)(A).

328. See *supra* text accompanying notes 92-93.

329. See *supra* text accompanying notes 87-90.

330. Confessore, *supra* note 249, at A1.

be required to have one full-time licensed psychiatrist on staff for every 100 juveniles in a detention center.<sup>331</sup>

After the initial mental assessment, states should begin to develop discharge plans for incarcerated juveniles.<sup>332</sup> In order to ensure compliance with this mandate, state juvenile courts should require a pre-release hearing to confirm that an appropriate discharge plan is in place.<sup>333</sup>

Legislative action is clearly necessary to combat the problems associated with minority children's mental health issues.<sup>334</sup> To increase the accountability of state juvenile justice systems, the reauthorization of the JJDPa must provide national standards for the treatment of mentally ill juvenile offenders.<sup>335</sup> Once these standards are in place, the DOJ can hold states accountable for failure to meet these standards.<sup>336</sup>

### *E. Ending the Prison Cycle*

In light of cultural barriers, financial obstacles, and community influences, written discharge plans are not sufficient to ensure mentally ill minority youth will seek treatment when they return to their communities.<sup>337</sup> Instead, state juvenile justice systems should create reentry programs to provide youth with services for a successful reintegration back into their communities. The New York City Department of Juvenile Justice Collaborative Family Initiative Program ("CFI")<sup>338</sup> should serve as a national model for reentry programs.

CFI is a collaborative effort between the Department of Juvenile Justice ("DJJ"), community-based organizations ("CBO"), and the families of released juvenile offenders.<sup>339</sup> The program has three phases. First, there is a pre-discharge meeting with the juvenile, his or her family, a counselor from the CBO, and the DJJ discharge team member to discuss the juvenile's discharge plan and health insurance reenrollment.<sup>340</sup> After release, a counselor visits the youth at home to review the discharge plan, discuss any family concerns, and detail program logistics, including location and transportation to the CBO.<sup>341</sup>

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331. See H.R. 6029 § 271(d)(2)(C).

332. *Id.* § 205(1)(S)(33)(A)(i).

333. *Id.* § 205(1)(S)(33)(B)(ii).

334. See *supra* Part III.B.

335. See *supra* Part III.B.

336. See *supra* text accompanying notes 249-60.

337. CFI REPORT, *supra* note 108, at 12; see *supra* Part II.D.

338. CFI REPORT, *supra* note 108, at 6.

339. *Id.* at 13.

340. *Id.* at 39 app. A.

341. *Id.*

Shortly thereafter, the youth begins a ninety-day mental health treatment program at the CBO.<sup>342</sup> CFI only engages a CBO that is located within the youth's community and could provide culturally appropriate mental health services.<sup>343</sup> The DJJ discharge team tracks the success of the program participants and identifies areas of the program that need improvement.<sup>344</sup>

The CFI pilot program was extremely successful. Seventeen of the twenty-one participants were not rearrested during the ninety-day treatment program.<sup>345</sup> Additionally, all the youth in the program returned to school within thirty days of their release from the DJJ.<sup>346</sup> In short, the coordination of services between a state juvenile justice system and community organizations will provide minority youth with the best aftercare options.

## V. CONCLUSION

The need for all of us to address mental health issues cannot be overstated, as the recent tragedy in Arizona should remind us. On January 8, 2011, Jared Loughner opened fire outside a supermarket, killing six and injuring fourteen, including U.S. Congresswoman Gabrielle Giffords.<sup>347</sup> In the aftermath of the tragic shooting, the entire nation sought answers to why the officials at the community college Loughner attended did not have him involuntarily committed to a mental health hospital.<sup>348</sup> Loughner showed several warning signs that he was dangerous and mentally unstable.<sup>349</sup> Yet, nothing was done.<sup>350</sup> Although relatively little is known about Loughner's mental health prior to community college,<sup>351</sup> many young adults' disorders manifest in childhood.<sup>352</sup> For example, Cho Seung-Hui, the Virginia Tech student who shot thirty-two people dead at his school, showed signs of a mental

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342. *Id.*

343. *Id.* at 13.

344. *Id.* at 39 app. A.

345. *Id.* at 30, 33.

346. *Id.* at 31.

347. Kate Pickert & John Cloud, *If You Think Someone Is Mentally Ill: Loughner's Six Warning Signs*, TIME (Jan. 11, 2011), <http://www.time.com/time/nation/article/0,8599,2041733,00.html>.

348. *Id.*

349. *Id.*

350. *Id.*

351. *See id.*

352. *See supra* text accompanying notes 28-31, 155-56.



illness from the tender age of nine.<sup>353</sup> But like many children in the United States, Seung-Hui never received the appropriate treatment.<sup>354</sup>

Society has a moral responsibility to ensure that our children are provided with effective mental health support including prevention, intervention, treatment, and aftercare. The warehousing of minority children in the juvenile justice system is not the answer to preventing these children from committing inexplicable crimes. In order to address the warehousing issue, Congress must reform federal laws on mental health treatment both in the school system and at different stages of the juvenile justice system.<sup>355</sup> The school-to-prison pipeline must end.<sup>356</sup> We often wait until the youth reaches the juvenile justice system to address his or her mental health disorder.<sup>357</sup> By then, it is too late because juvenile detention centers lack the appropriate facilities to provide mental health treatment.<sup>358</sup>

The long-term consequences of not providing minority youth with appropriate mental health treatment are costly—both to the individual child and to society.<sup>359</sup> These children will become victims of their disorders. Even worse, when society fails our children, no one escapes the consequences.

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353. Mike Nizza, *Seung-Hui Cho: Who Is This Man?*, THE LEDE (Aug. 30, 2007, 3:46 PM), <http://thelede.blogs.nytimes.com/2007/08/30/seung-hui-cho-who-is-this-man/>; Pickert & Cloud, *supra* note 347.

354. Pickert & Cloud, *supra* note 347.

355. *See supra* Part III.

356. *See supra* Part III.A.

357. *See supra* Part II.A–B.

358. *See supra* Part II.C.

359. *See supra* Part II.E.

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